

DR. P.K. Srivastava  
Dr. (Mrs) G.Srivastava

**SOUTHNORWOOD MEDICAL PRACTICE**

21b South Norwood Hill  
South Norwood  
SE25 6AA  
020 8653 0635

CONFIDENTIAL  
DATE:

**PATIENT'S QUESTIONNAIRE**

Title:	Surname	First Name(s)
Address :		Telephone No.
Post Code:		

Date of Birth:	Age:	Occupation:
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Marital Status	Single	Married	Divorced	Separated	Remarried	Widowed	Cohabit
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Height		Next of Kin:
Weight		Contact Details:

**Children Only**

**Childhood Immunisation- Children under Five, please provide RED BOOK (Immunisation Records)**

*Please tick as appropriate*

**SMOKING DATA**

Smoking Status	Never Smoked	Smoker	Stopped Smoking Date :	
Types	Cigarettes	Cigars	Tobacco(Roll ups)	Pipe
How many a day				

**ALCOHOL**

Do you drink	Yes	sometime	stopped	never
Unit a week				

*Alcohol: Pint of reg beer/lager/cider = 2units, Alcopop or can of lager = 1.5units, Glass of wine 9175ml) = 2 units, Bottle of Wine = 9 units, Single measure of sprits = 1 unit*

**How often do you have an alcoholic drink?**

0=never    1 = Monthly or less    2 = 2-4 times per month    3 = 2-3 times per week    4 = 4+times per week

**How many do you have on a typical day?**

0 = 1-2    1 = 3-4    2 = 5-6    3 = 7-8    or 4 = 10+

**How often do you have 6 + standard units?**

0= Never    4 = Daily or almost daily    3 = Weekly    1 = less than monthly    2 = Monthly

**MEDICATIONS:**

If you are on regular Medication please provide all details  
(Request slip from previous GP/Medication boxes)

***Women Only***

Using any Contraception (i.e. Pill, Coil etc.)	YES/NO
Do you have regular Cervical Smear	YES/NO
Date of Last Cervical smear	
Post-menopausal Since what age	YES/NO

***Chronic Disease***

Please tick if you or your family members suffer from any of the following:

	Self	Family(who)
Asthma		
Diabetes		
Epilepsy		
High Blood Pressure		
Heart Disease		
Stroke		
Cancer		
Depression		
Any other Disease		

***Operations & Hospital Admissions***

Please list any operations and/or reasons for hospital stay(s) with dates (if known)

Date	Reason

***Your Ethnic Origin***

WHITE	ASIAN OR ASIAN BRITISH	MIXED
White British	Indian	White and Black Caribbean
White Irish	Pakistani	White and Black African
Other White Ethnic group	Bangladeshi	Other Ethnic Asian/white
	Other Asian Ethic group	Other Ethnic Other Mix origin
BLACK OR BLACK BRITISH		
Black Caribbean	OTHER ETHNIC GROUP	
Black African	Chinese	
Other Black Ethnic group	Other Ethnic group	

Main Languages Spoke: .....

Proof of ID/Address Seen: YES/NO

Type of Documents Seen:

Checked by:

Date: